

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15959

CERTIFICATE OF DEATH

15950

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>LIGUORI</b> Last <b>BEAVAN</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>4</b> Year <b>19 67</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 5, 1894</b>	9. AGE (In years last birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES PAUL ABELL</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE ELLEN HAMMETT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT Address <b>AGNES DORIS JONES CALLAWAY, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sept Embolism of aorta from atherosclerosis</b> DUE TO <b>Fract. of hip and of humerus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>41</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 3, 1967</b> to <b>Nov 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 3, 1967</b> , and that death occurred at <b>4:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Michael Barbarich</b>				22b. DATE SIGNED <b>NOV. 5, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>MICHAEL BARBARICH, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>NOV. 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY FACE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>GREAT MILLS ST. MARY'S MD.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. WELCH</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James M. Welch</b>	

10-10-10

STATE OF TEXAS

10-10-10

IN SENATE,  
January 10, 1910.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1909.  
BY  
J. W. HARRIS,  
COMMISSIONER.  
RECEIVED  
JAN 11 1910  
STATE OF TEXAS  
LAND OFFICE  
DAVIDSON BUILDING  
DALLAS, TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15950

CERTIFICATE OF DEATH

15951

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COMPTON</b>		c. LENGTH OF STAY IN It <b>24 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL COMPTON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SUSAN</b> First <b>ALBERTA</b> Middle <b>BOWLES</b> Last				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>12</b> Year <b>19 67</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 10, 1910</b>		9. AGE (In years last birthday) <b>57</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS D. ELLIS</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. BAILEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>JOHN I. BOWLES JR. Rt. 1 LEONARDTOWN, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1538</b> IMMEDIATE CAUSE (a) <b>Hepatic Insufficiency</b> DUE TO (b) <b>metastases to liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Adeno Carcinoma Colon</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>18 mo.</b> <b>18 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>John F. Fenwick</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11.15.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. FENWICK M. D.</b>				22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 15, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CHURCH</b>		23d. LOCATION (City or Town) (County) (State) <b>MORGANZA, ST. MARY'S, MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15961

**CERTIFICATE OF DEATH**

15953

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ST. MARY'S</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN b. <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL VALLEY LEE.</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>FLORA CHRISTINE BRISCOE</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>NOVEMBER 6, 19 67</b>				
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>COLORED</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>DEC. 16, 1921</b>		<b>9. AGE</b> (In years last birthday) <b>45</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>? ?</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>AMANDA SOMERVILLE</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>214 302426</b>		<b>17. INFORMANT</b> Address <b>ERNEST G. BRISCOE SAME AS # 2 ABOVE</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acidosis &amp; Circulatory Collapse</b> DUE TO (b) <b>Uremia</b> DUE TO (c) <b>Chronic Hemodialysis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b> <b>10 hrs</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11/6, 1966</b> <b>to</b> <b>11/6, 1967</b> <b>that (I) (we) last saw the deceased alive on</b> <b>11/6, 1967</b> <b>and that death occurred at</b> <b>11/6, 1967</b> <b>from causes on and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>JAMES B. JARBOE</b>		<b>22b. DATE SIGNED</b> <b>11/11/67</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JAMES B. JARBOE M.D.</b>			
<b>22d. ADDRESS</b> <b>GREAT MILLS, MARYLAND</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>Nov. 9, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ST. MARKS CEMETERY</b>			
<b>23d. LOCATION</b> (City or Town) (County) (State) <b>VALLEY LEE, ST. MARY'S, MARYLAND</b>							
<b>24. FUNERAL DIRECTOR</b> <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 14 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>			

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<div>15962</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>15954</div>									
1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>			c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. GEORGE ISLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARVIN</b> Middle <b>FRANKLIN</b> Last <b>BROWN</b>					4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>14</b> Year <b>1967</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 1, 1892</b>		9. AGE (In years last birthday) <b>75</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <b>MINNIE CHESBER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>GERALDINE BROWN</b> Address <b>ST. GEORGE ISLAND, MARYLAND</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>357X</b> IMMEDIATE CAUSE (a) <b>Paralysis of vital centers</b> DUE TO (b) <b>Friedreich's ataxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b> <b>30 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 13, 1967</b> , to <b>Nov 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 13, 1967</b> , and that death occurred at <b>12:45 AM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>P. J. BEAN</b> M.D.					22b. DATE SIGNED <b>Nov 10/67</b>		22c. PHYSICIAN'S NAME (Type)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE THEREOF <b>Nov. 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGE ISLAND</b>		
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>					25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

ST. MARY'S HOSPITAL, BALTIMORE, MARYLAND

1915

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15963

15955

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BUSHWOOD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BUSHWOOD</b>	
c. LENGTH OF STAY IN TB <b>LIFE</b>		d. STREET ADDRESS <b>12-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>GARRETT</b> Last <b>CHESELDINE</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 3, 1913</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FREIGHT</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BUSHWOOD, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GARRETT CHESELDINE</b>		14. MOTHER'S MAIDEN NAME <b>MARY L. GASS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARY P. CHESELDINE</b>		Address <b>BUSHWOOD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoxia</b> DUE TO <b>metastatic obstruction airway</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous cell Carcinoma tongue</b> (c) <b>1 1/2 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 wk</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>11.30.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. FENWICK M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-1-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>	23d. LOCATION (City or Town) (County) (State) <b>BUSHWOOD, ST. MARY'S, MD.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	
25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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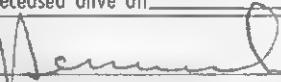
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

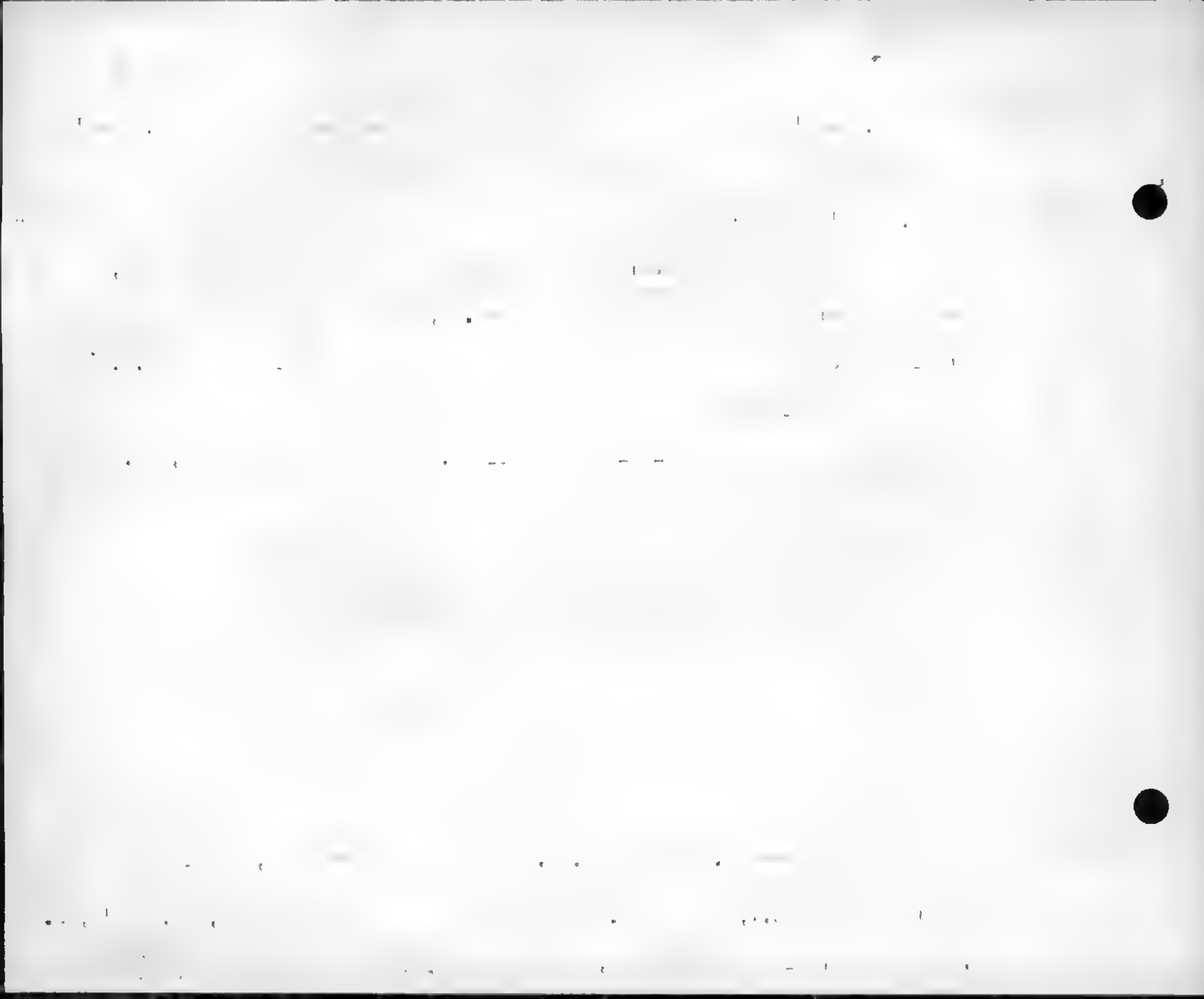
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN TB <b>6 MONTHS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM MARRICE CLEMENTS</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 28, 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1886</b>
9. AGE (In years lost birthday) yrs <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CLEMENTS</b>		14. MOTHER'S MAIDEN NAME <b>ROSA JARBOE</b>	
15. WAS DECEASED EVER IN U.S. ARMO FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>66 to yes W W I</b>		16. SOCIAL SECURITY NO. <b>578-48-8399</b>	
17. INFORMANT <b>DELLA R. CLEMENTS</b>		Address <b>LEONARDTOWN, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10yr</b> <b>10yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>11.30.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. FENWICK M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Dec. 1, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. ANDREWS</b>	23d. LOCATION (City or Town) (County) (State) <b>LEONARDTOWN, ST. MARY'S, MD.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE 	



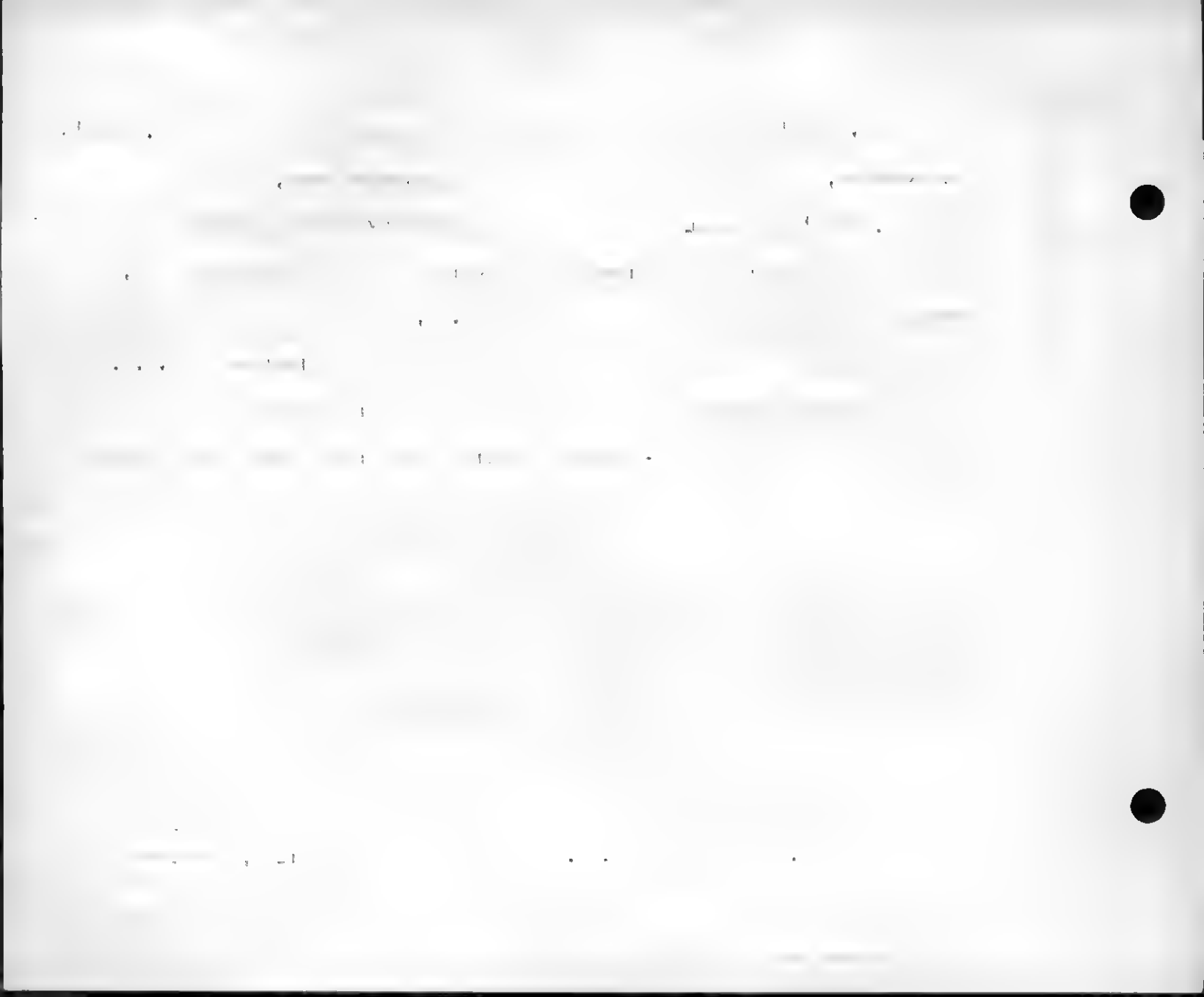
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10057

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>ST. MARY'S</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN.</b>		c. LENGTH OF STAY IN 16 <b>12 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON PARK.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>			d. STREET ADDRESS <b>LORD CALVERT TRAILER PARK</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>HAZEL</b> Middle <b>VIRGINIA</b> Last <b>COLLINE</b>			4. DATE OF DEATH <b>NOVEMBER 2, 19 67</b>		
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 29, 1905</b>		9 AGE (In years last birthday) <b>62</b> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>PRESTON SWEIGERT</b>		
14. MOTHER'S MAIDEN NAME <b>HARREET CHUNEY</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> ****		
16 SOCIAL SECURITY NO <b>218-26-6780</b>		17. INFORMANT Address <b>WILLIAM COLLINS SAME AS # 2 ABOVE</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis, genl.</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>5-6 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21 I certify that (I) (this hospital) attended the deceased from <b>10/20, 1967</b> to <b>Nov 2, 1967</b> , that (I) (we) lost the deceased alive on <b>Nov 1, 1967</b> , and that death occurred at <b>Nov 2, 1967</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>J. Roy Guyther</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>NOV. 2, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. ROY GUYTHER M. D.</b>		22d. ADDRESS <b>MECHANISVILLE, MARYLAND</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LUTHERAN CHURCH CEM</b>	
23d. LOCATION (City or Town) <b>BAKERSVILLE, WASH. CO.</b>		(County)		(State) <b>MD</b>	
24. FUNERAL DIRECTOR <b>ROUZER FUNERAL HOME HAGERSTOWN, MARYLAND</b>		25. DATE BY REGISTRAR <b>NOV 6 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15968

1958

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MECHANICSVILLE</b>	
c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		d. STREET ADDRESS <b>R F D Box 355</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JEANETTE ELIZABETH CURTIS</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 7, 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 25, 1906</b>
9. AGE (In years last birthday) <b>61 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS GRAY</b>		14. MOTHER'S MAIDEN NAME <b>JANIE WOODLAND</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>JAMES G. CURTIS</b>		Address <b>SAME AS # 2 ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>331x</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 6 1967</b> to <b>Nov 7 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 6 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J Roy Guyther</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>J Roy Guyther M.D.</b>		22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Nov. 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>MORGANZA, ST. MARY'S, MARYLAND</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

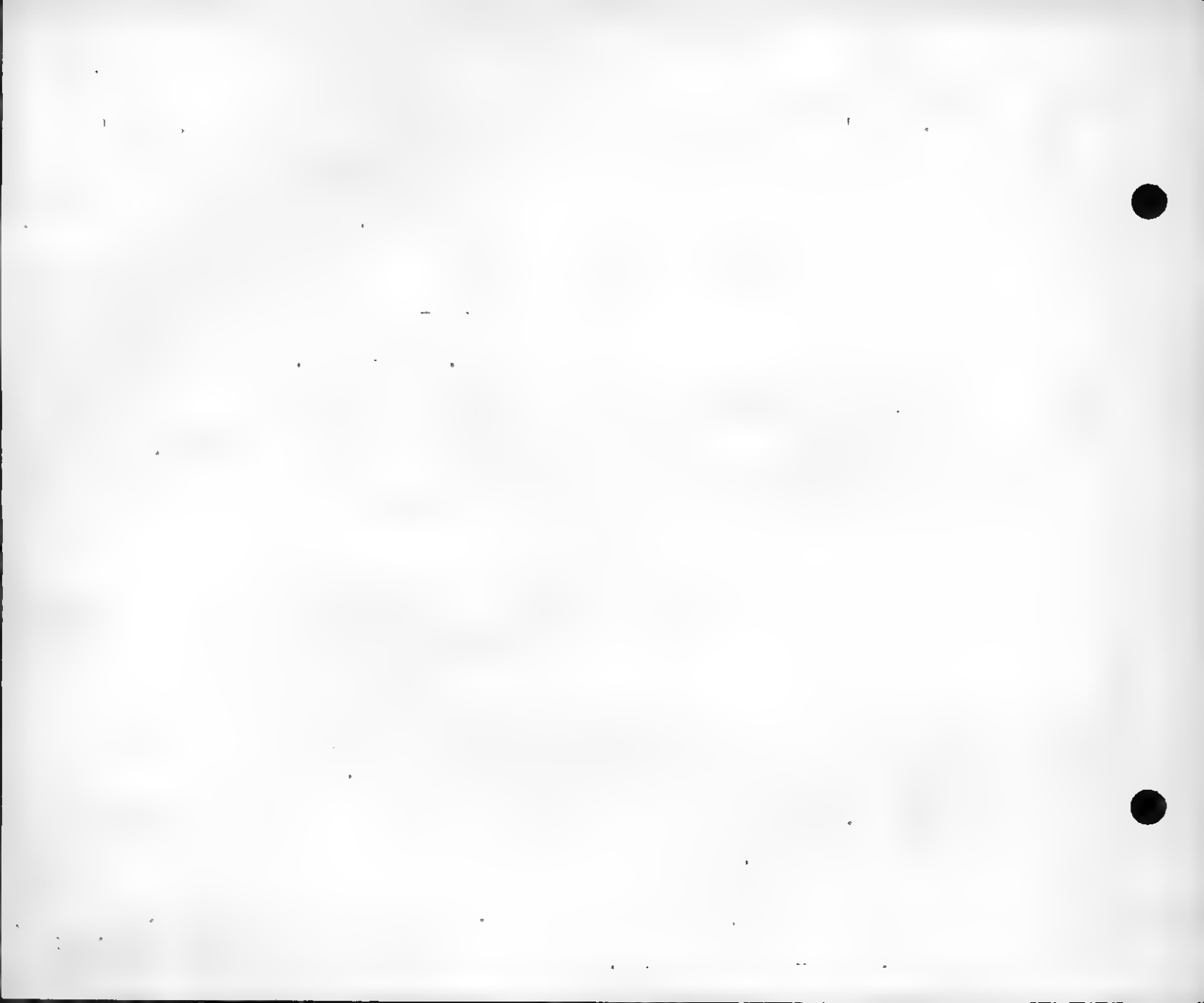
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PATUXENT RIVER</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>STATION HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON PARK</b> d. STREET ADDRESS <b>RIDGE MD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>KURT ALLAN DALKIN</b>			4. DATE OF DEATH Month Day Year <b>NOV 25 19 67</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-23-67</b>		9. AGE (in years lost birthday) yrs <b>0 2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>ST. MARY'S, MD.</b>	
13. FATHER'S NAME <b>DARRELL HOWARD DALKIN</b>			14. MOTHER'S MAIDEN NAME <b>NORALEA WILLOUGHBY</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>FATHER</b> Address <b>RIDGE MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>HYALINE MEMBRAN DISEASE</b> <b>7735</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PREMATURITY</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>23 NOV 19 67</b> , to <b>25 NOV 19 67</b> , that (I) (we) last saw the deceased alive on <b>25 NOV 19 67</b> , and that death occurred at <b>7:55 PM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>James R. ABEL</b>		22b. DATE SIGNED <b>25 NOV 67</b>		22c. PHYSICIAN'S NAME (Type) <b>James R. ABEL</b>	
22d. ADDRESS <b>Same as #1</b>					
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER CEM.</b>	
23d. LOCATION (City or Town) (County) (State) <b>GREAT MILLS, MD.</b>					
24. FUNERAL DIRECTOR <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

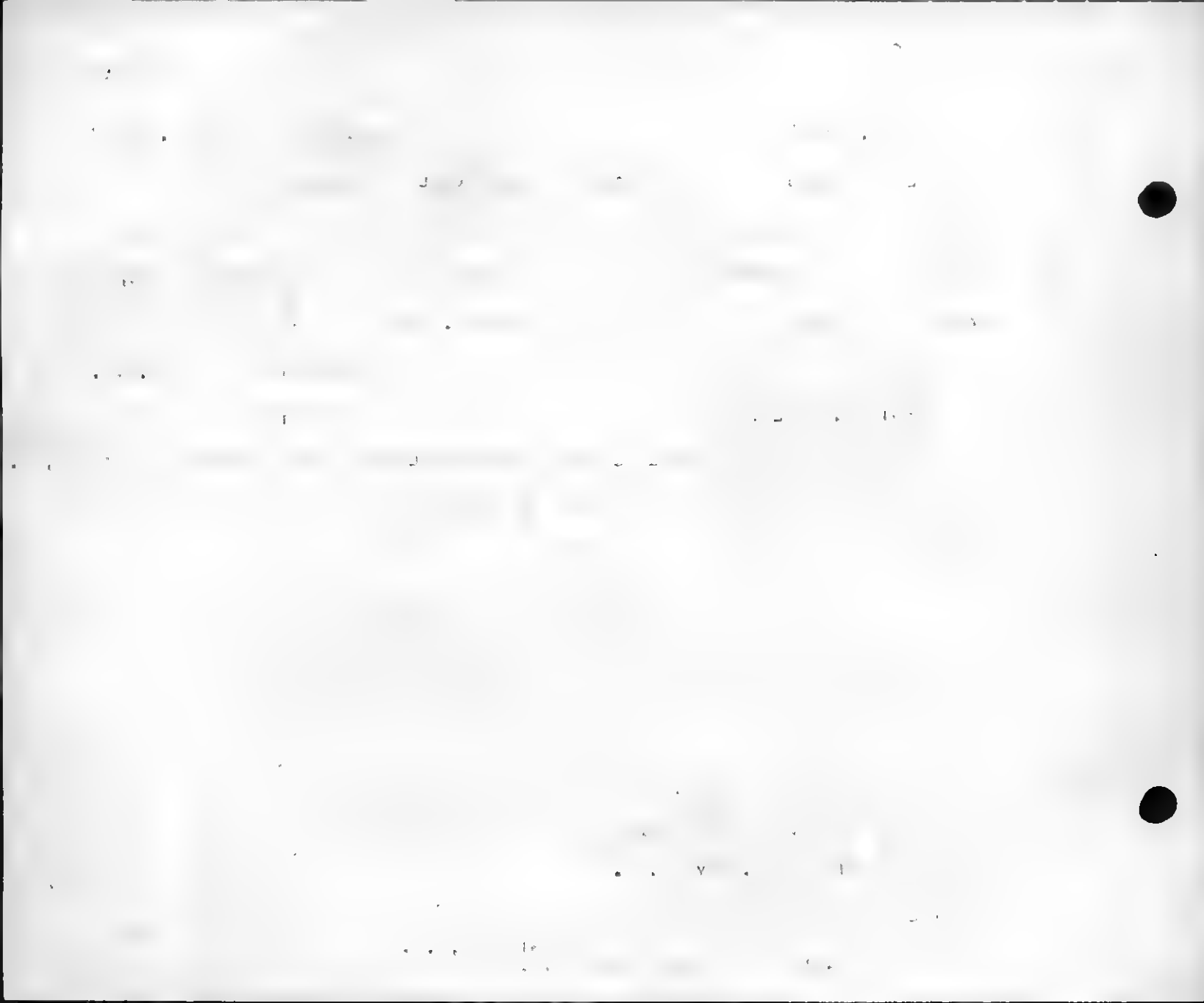
VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15968

10000

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BUSHWOOD</b>		c. LENGTH OF STAY IN 1b <b>WEEK 7 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED <b>Ithamar</b> First Middle Last (Type or print) <b>ITHAMAR E EGGLETON</b>		4 DATE OF DEATH <b>NOVEMBER 12, 1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 B. DATE OF BIRTH <b>AUG 7, 1897</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11 BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
13 FATHER'S NAME <b>JESSIE B. EGGLETON</b>		14. MOTHER'S MAIDEN NAME <b>? FONTAINE</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>231-16-8432</b>	
17 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of Lung</b> 10000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd M.D.</b> EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M.D.</b>		22. DATE SIGNED <b>11/13/67</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-16-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Harmony Park</b>		23d LOCATION (City or Town) (County) (State) <b>Landover Md</b>	
24. FUNERAL DIRECTOR <b>ARTHUR L. ROLLINS</b>		25a. REC'D BY REGISTRAR <b>WASHINGTON, D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Rollins</b>		DATE <b>NOV 15 1967</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b <b>20 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S NURSING HOME</b>		d. STREET ADDRESS <b>MORGANZA</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROSE LUCINA FORBES</b>		4 DATE OF DEATH Month Day Year <b>NOVEMBER 27, 1967</b>	
5. SEX <b>FEMALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 6, 1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	9 AGE (in years last birthday) <b>67</b> yrs
11 BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL HEBB</b>		14. MOTHER'S MAIDEN NAME <b>MARY PRICE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>217* 42-3934</b>		17. INFORMANT <b>LOUIS E. FORBES MORGANZA, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral haemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Cerebral arteriosclerosis</b> (c) <b>Cerebral arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 26, 1967</b> to <b>Nov 27, 1967</b> , that (I) (we) lost the deceased alive on <b>Nov 26, 1967</b> , and that death occurred at <b>5 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>DAVIS MOSSMAN M. D.</b>		22b. DATE SIGNED <b>11-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVIS MOSSMAN M. D.</b>		22d. ADDRESS <b>MECHANICSVILLE, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/30/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH</b>	23d. LOCATION (City or Town) (County) (State) <b>MORGANZA ST. MARY, Md.</b>
24. FUNERAL DIRECTOR <b>W. C. CLARKE MATTINGLEY, LEONARDTOWN Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>



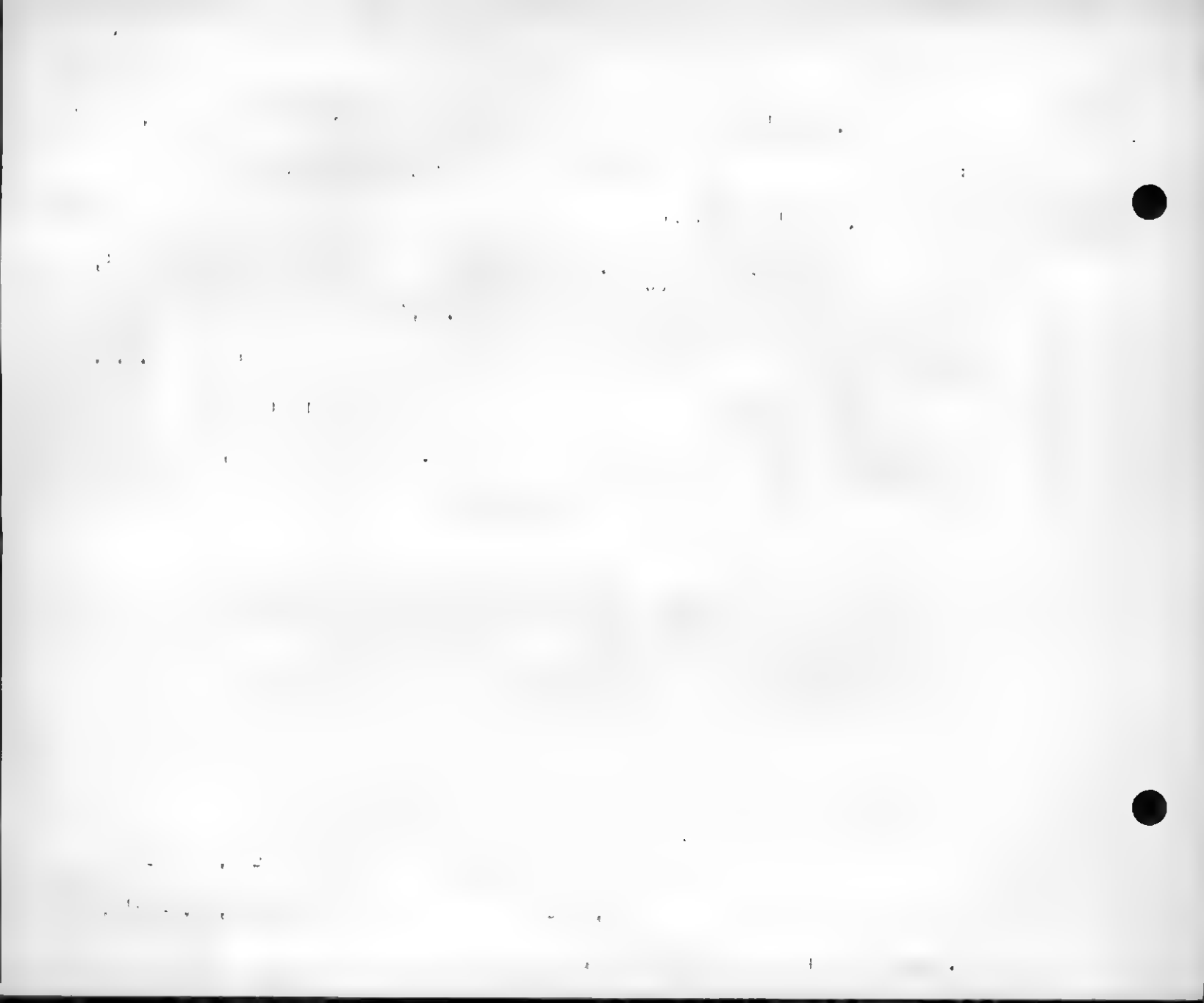
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
15970 Item #236 Film #G395 11/25/67  
**CERTIFICATE OF DEATH**

15932

1 PLACE OF DEATH a COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b COUNTY <b>ST. MARY'S</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c LENGTH OF STAY IN TB <b>19 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE K. GREEN</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 21, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 14, 1882</b>
9. AGE (In years most birthday) <b>85</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>HENRY GREEN</b>		14 MOTHER'S MAIDEN NAME <b>ROBETTA WILLIAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ROBERT V. YOUNG BRYANTOWN, MARYLAND</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1967</u> , to <u>Nov 1967</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u>		22b DATE SIGNED <u>11-22-67</u>	
22c PHYSICIAN'S NAME (Type) <b>MECHANICSVILLE, MARYLAND</b>		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>Nov. 25, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>	23d. LOCATION (City or Town) (County) (State) <b>NEW MARKET, ST. MARY'S, MARYLAND</b>
24 FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a REC'D BY REGISTRAR DATE <b>NOV 24 1967</b>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

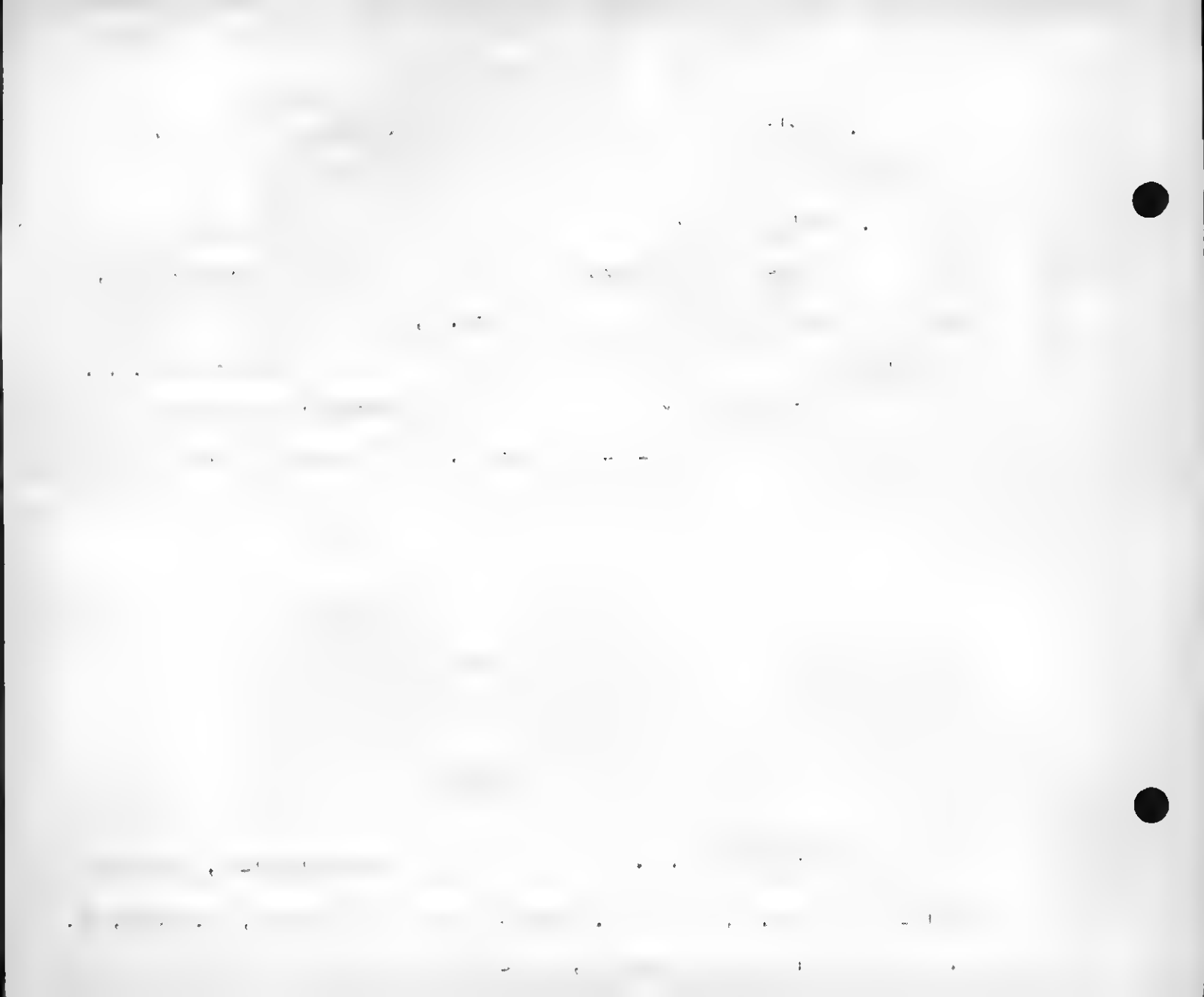
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15971

15863

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN TB <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>MORGANZA</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES THOMAS GUY</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 11, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 14, 1911</b>
9. AGE (in years last birthday) <b>56 yrs</b>		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN EDWARD GUY</b>		14. MOTHER'S MAIDEN NAME <b>MARY KXXXXX BLANCHE GRAVES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-12-2058</b>	
17. INFORMANT <b>MARY T. GUY SAME AS # 2 ABOVE</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO <b>Generalized ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>11/11/67</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>11</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Leon Berube</b> 22c. PHYSICIAN'S NAME (Type) <b>LEON BERUBE M. D.</b>		22b. DATE SIGNED <b>NOV 17 1967</b> 22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 14, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPHS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MORGANZA, ST. MARY'S, MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1-103. Page 5 may be retained for your files.

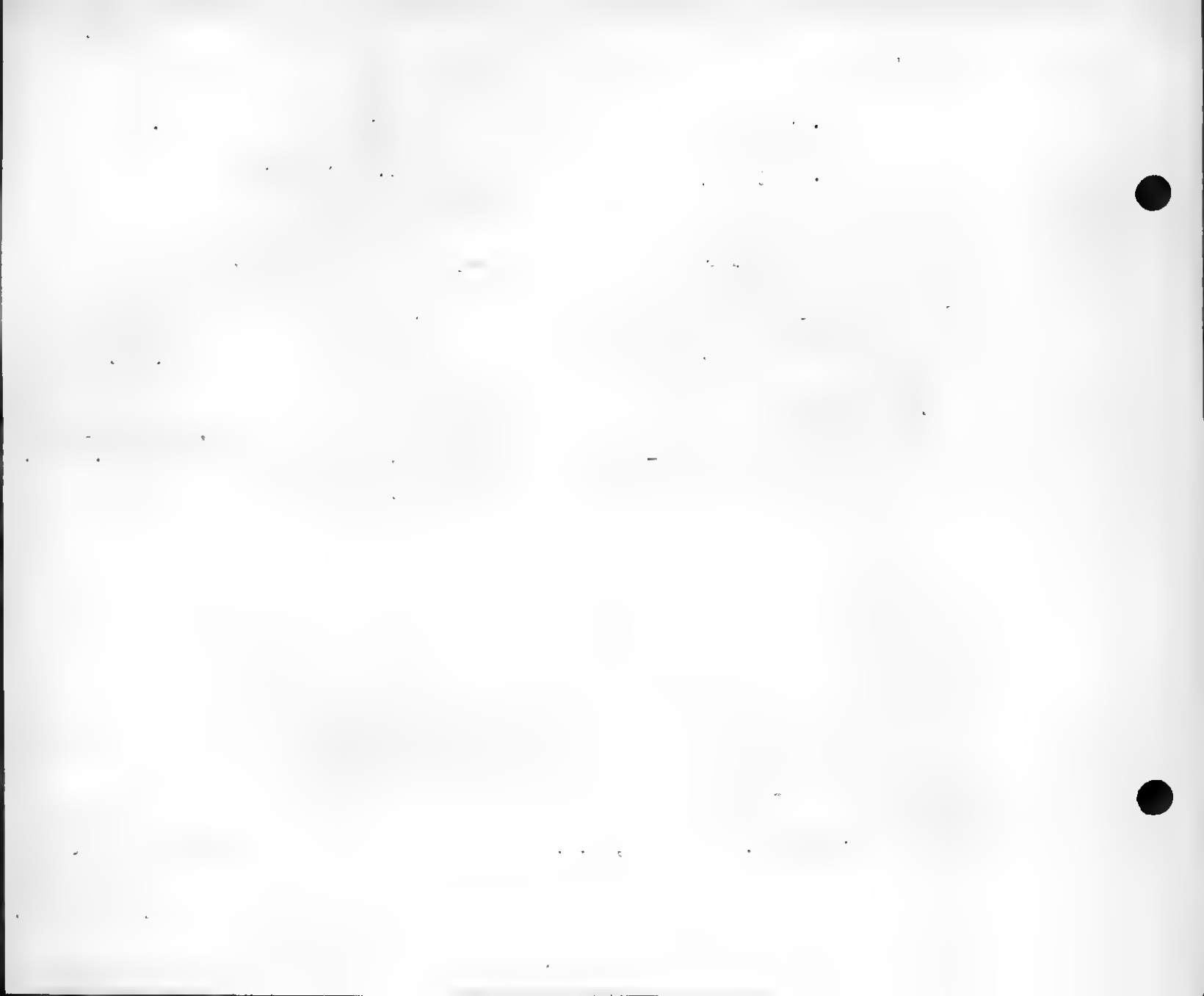
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>ST. MARYS</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>ST. MARYS</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Mary City</b>		c LENGTH OF STAY IN 1b <b>12 1</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <b>STEVEN</b> Middle <b>HOLISKEY</b> Last <b>HOLISKEY</b>		4 DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>AUG. 8, 1912</b>
9 AGE (in years last birthday) <b>55</b> yrs		10 UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min <b>55</b>	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>CARPENTER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>PUBLIC WORKS</b>	
11 BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOSEPH HOLISKEY</b>		14 MOTHER'S MAIDEN NAME <b>MARY KUMPAN</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO. <b>217-14-4726</b>	
17 INFORMANT <b>JOSEPHINE M. HOLISKEY</b>		18 ADDRESS <b>RT. 1, Box 61 GLENCOE NEW SMYRNA BCH., FLA.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>440X IMMEDIATE CAUSE (a) Lobar pneumonia</b> DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		22. DATE SIGNED <b>November 16, 1967</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>11-18-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>ST. JAMES CEMETERY</b>		23d LOCATION (City or town) (County) (State) <b>LEXINGTON PARK ST. MARY'S MD.</b>	
24 FUNERAL DIRECTOR <b>JOHN M. WELCH</b>		25a REC'D BY REGISTRAR <b>NOV 22 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c ADDRESS <b>LEONARDTOWN, MD.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

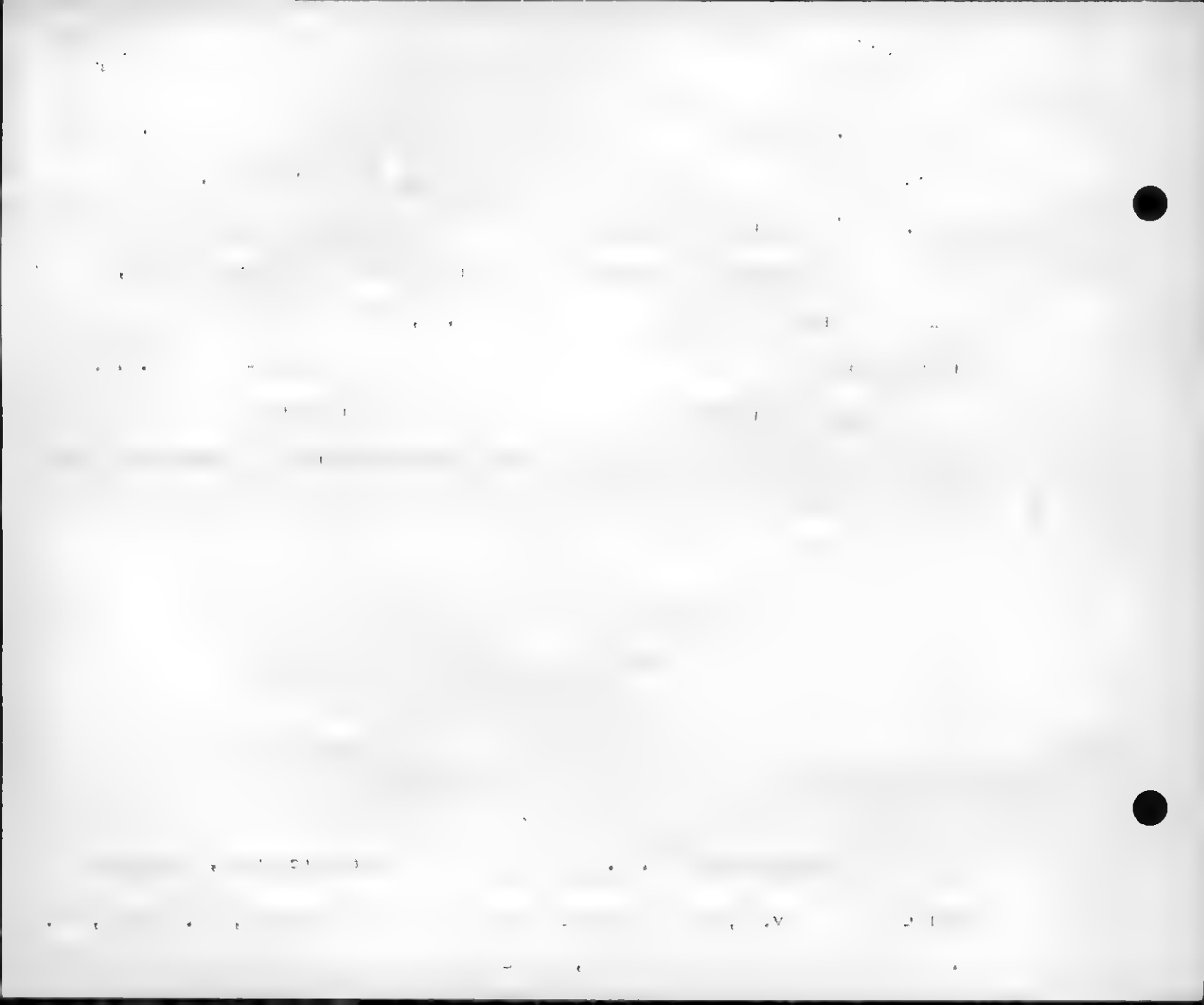
15365

15973

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c. LENGTH OF STAY IN 1b <b>10 MONTHS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S NURSING HOME</b>				d. STREET ADDRESS <b>RURAL MECHANICSVILLE,</b>			
3 NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>BENEDICT</b> Last <b>HUNTINGTON</b>				4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>14</b> Year <b>19 67</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 20, 1884</b>		9 AGE (In years last birthday) <b>83</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS HUNTINGTON</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE HILL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS JEANETTE HUNTINGTON SAME AS # 2 ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500</b> DUE TO <b>arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>67</b> , to <b>Nov</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov</b> , 19 <b>67</b> , and that death occurred at <b>11</b> M, from causes and on the date stated above							
22a. SIGNATURE <b>David Mossman</b>				22b. DATE SIGNED <b>11-15-67</b>		22c. PHYSICIAN'S NAME (Type) <b>DAVID MOSSMAN M. D.</b>	
22d. ADDRESS <b>MECHANICSVILLE MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BUSHWOOD, ST. MARY'S, MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

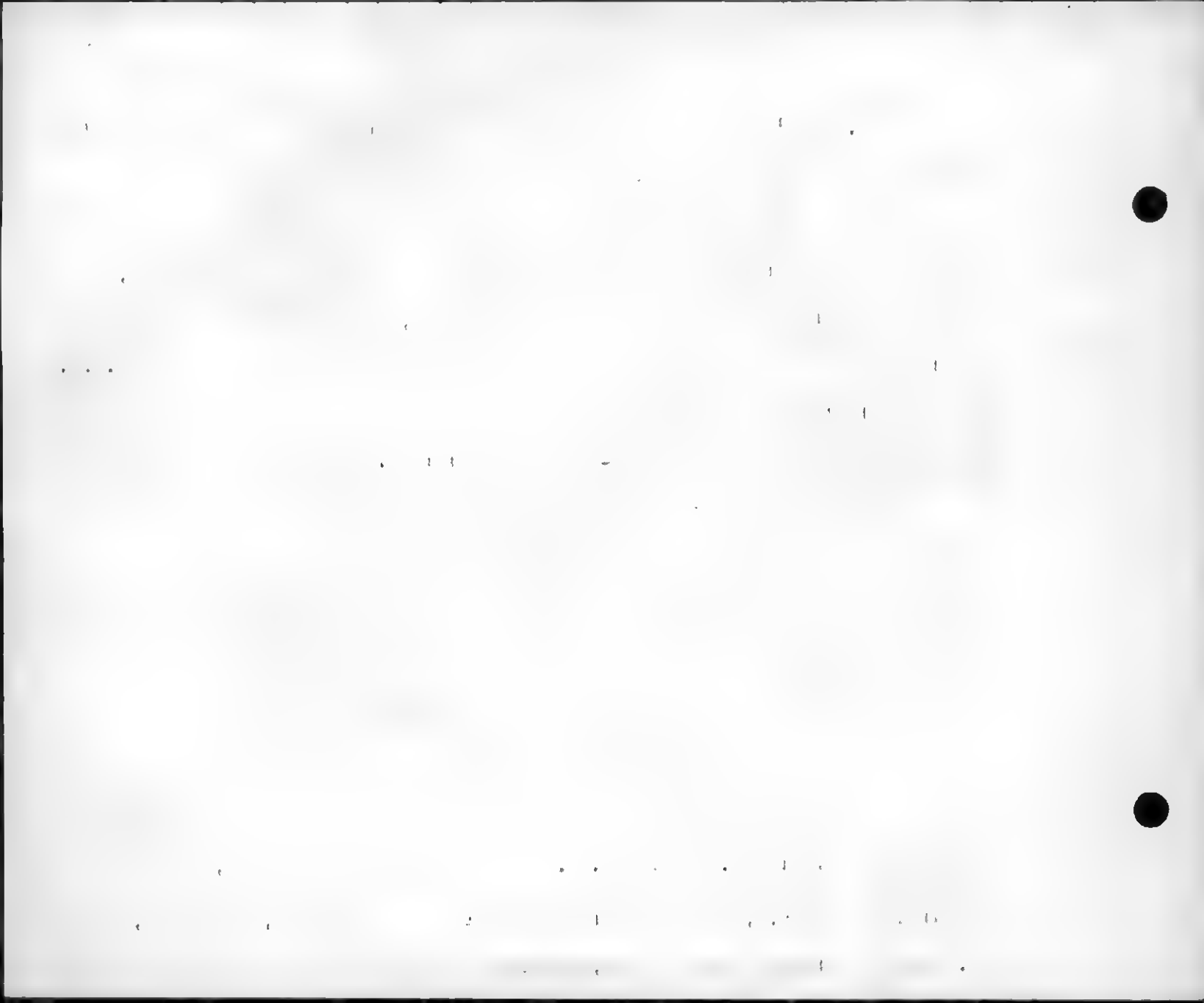
15974

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15066

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HOLLYWOOD</b>		c LENGTH OF STAY IN 1b <b>14 YEARS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ROUTE 1 Box 214</b>		d. STREET ADDRESS <b>ROUTE 1 Box 214</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>WILLARD FOSTER JONES</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 5, 1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>APRIL 28, 1888</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINISTER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>CLERGYMAN</b>	9 AGE (In years last birthday) yrs <b>79</b>
11 BIRTHPLACE (County & State, or foreign country)		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM ROBERT JONES</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA JANE PRINCE</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>226-14-8566</b>	
17. INFORMANT <b>MRS OLIVIA M. JONES</b>		Address <b>SAME AS # 2 ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>200X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prostatic Metastasis</b> DUE TO (c) <b>Diabetic Vascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>10 years</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1965</b> to <b>Nov 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 5, 1967</b> , and that death occurred at <b>2 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W. H. Patrick</b>		22b DATE SIGNED <b>11-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM H. PATRICK M. D.</b>		22d ADDRESS <b>LEXINGTON PARK, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>Nov. 8, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>TRINITY MEMORIAL</b>	23d LOCATION (City or Town) (County) (State) <b>WALDORF, CHARLES, MARYLAND</b>
24 FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a REC'D BY REGISTRAR <b>NOV 8 1967</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b REGISTRAR'S SIGNATURE <b>OT Thomas Judge</b>	





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

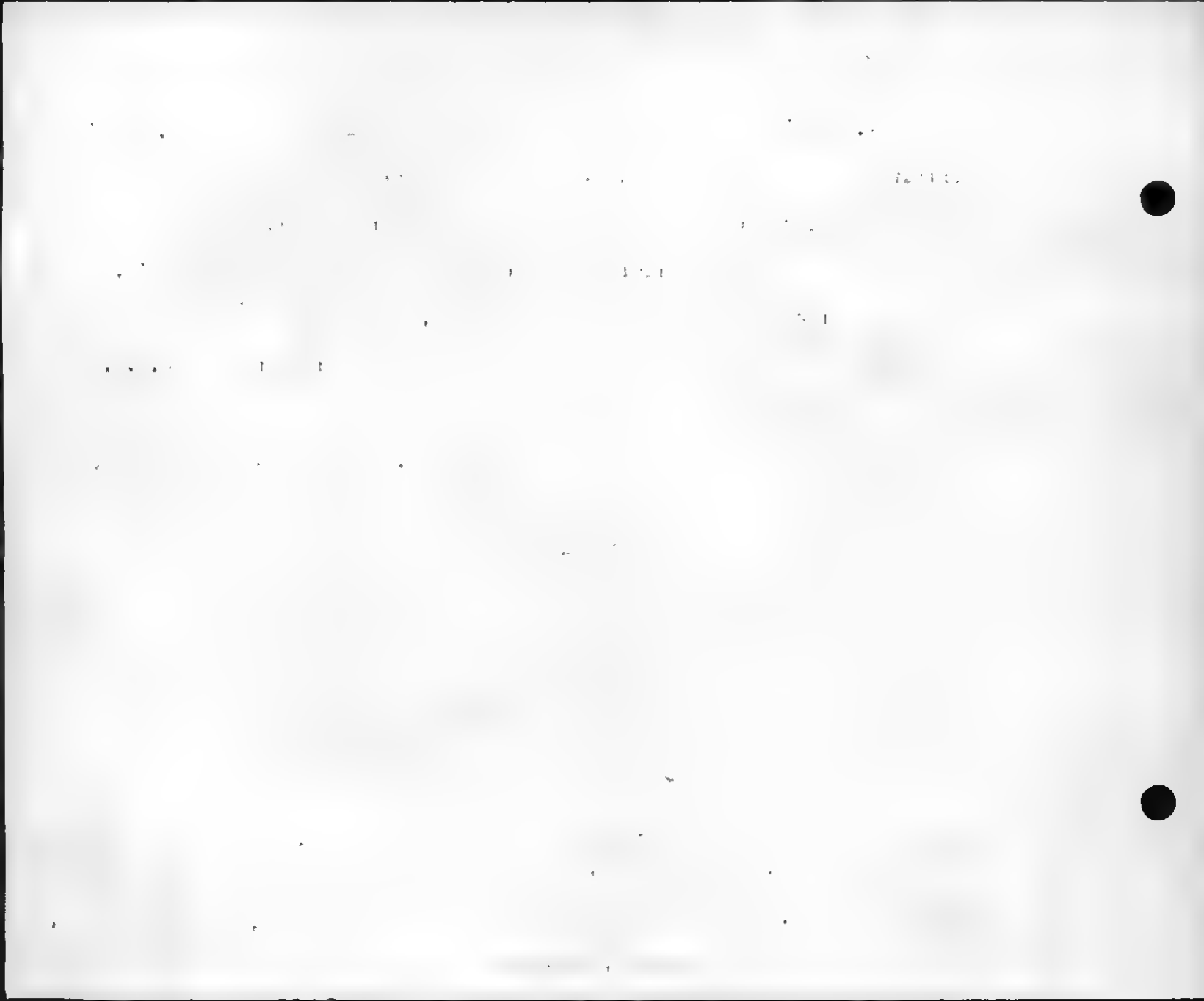
VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON</b>		c. LENGTH OF STAY IN 1b <b>24 HRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>167 CHINLEE DRIVE</b>		d STREET ADDRESS <b>167 CHINLEE DRIVE</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS WILLIAM KUBE</b>		4 DATE OF DEATH Month Day Year <b>NOVEMBER 10, 19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>JULY 5, 1917</b>
9 AGE (In years last birthday) <b>50</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BERNARD KUBE</b>		14. MOTHER'S MAIDEN NAME <b>? ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS JAMES L. MORGAN</b>		Address <b>SAME AS # 2 ABOVE</b>	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>asphyxiation - immediate</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>aspiration - immediate</b> DUE TO (c) <b>acute alcoholism</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William D. Boyd</i> EXAMINER'S NAME (Type) <b>William D. Boyd, MD, Asst. Med. Examiner</b>		22. DATE SIGNED <b>11/11/67</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>Nov. 14, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>THORN ROBE CEMETERY</b>	23d LOCATION (City or Town) (County) (State) <b>STAUNTON, VA.</b>
24. FUNERAL DIRECTOR <b>HAMRICK FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>NOV 17 1967</b>	
ADDRESS <b>STAUNTON, VIRGINIA</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #13111 #1395 11/21/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15876

15868

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL LEONARDTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pete's Willows Bar- Rt. 5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PETER CHRISTOPHER (CHRISTOS) LEVANIS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>17</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 5, 1918</b>
9. AGE (in years last birthday) <b>49</b> yrs		10. UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAR PROPRIETOR</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GREGORY LEVANIS</b>	
14. MOTHER'S MAIDEN NAME <b>?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>	
16. SOCIAL SECURITY NO <b>218-03-9468</b>		17. INFORMANT <b>MICHAEL LEVANIS</b> Address <b>BALTIMORE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>13X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd</b> M.D.		22. DATE SIGNED <b>11-18-67</b>	
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Nov. 20, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEK ORTHODOX</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE 7, MARYLAND</b>
24. FUNERAL DIRECTOR <b>MATTHEWS FUNERAL HOME 3021 EASTERN AVE.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Glenn A. Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15869

1 PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>St. Mary's</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NAS, Patuxent River</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Station Hospital</b>		d STREET ADDRESS <b>530 Saratoga Drive</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>June Stokes Longfellow</b>		4. DATE OF DEATH Month Day Year <b>November 14, 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Caucasian</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 JAN 1920</b>
9 AGE (In years lost birthday) yrs <b>47</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USMC/Dependent</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>1st Name Unknown (STOKES) deceased</b>		14 MOTHER'S MAIDEN NAME <b>Gertrude Wilderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>280-18-7547</b>	
17. INFORMANT <b>George M. Longfellow (H) same address.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Chronic Arteriosclerotic Cardiovascular Disease.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Myocardial Infarction</b>	
20c. TIME OF INJURY Month, Day, Year Hour o m <b>11:16 p.m. Nov. 14, 1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b>Home</b>	20f. (City or town) (County) (State) <b>Lexington Park, St. Mary's Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 14, 1967</b> to <b>Nov. 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 14, 1967</b> , and that death occurred at <b>3:40 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>John M. Welch</i>		22b. DATE SIGNED <b>14 NOV 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. S. LEIGHTON, LCDR, MC, USN</b>		22d. ADDRESS <b>NAS, Patuxent River, Md. 20670</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>NOV 20, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VA.</b>
24. FUNERAL DIRECTOR <i>John M. Welch</i> <b>JOHN M. WELCH</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>John M. Welch</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

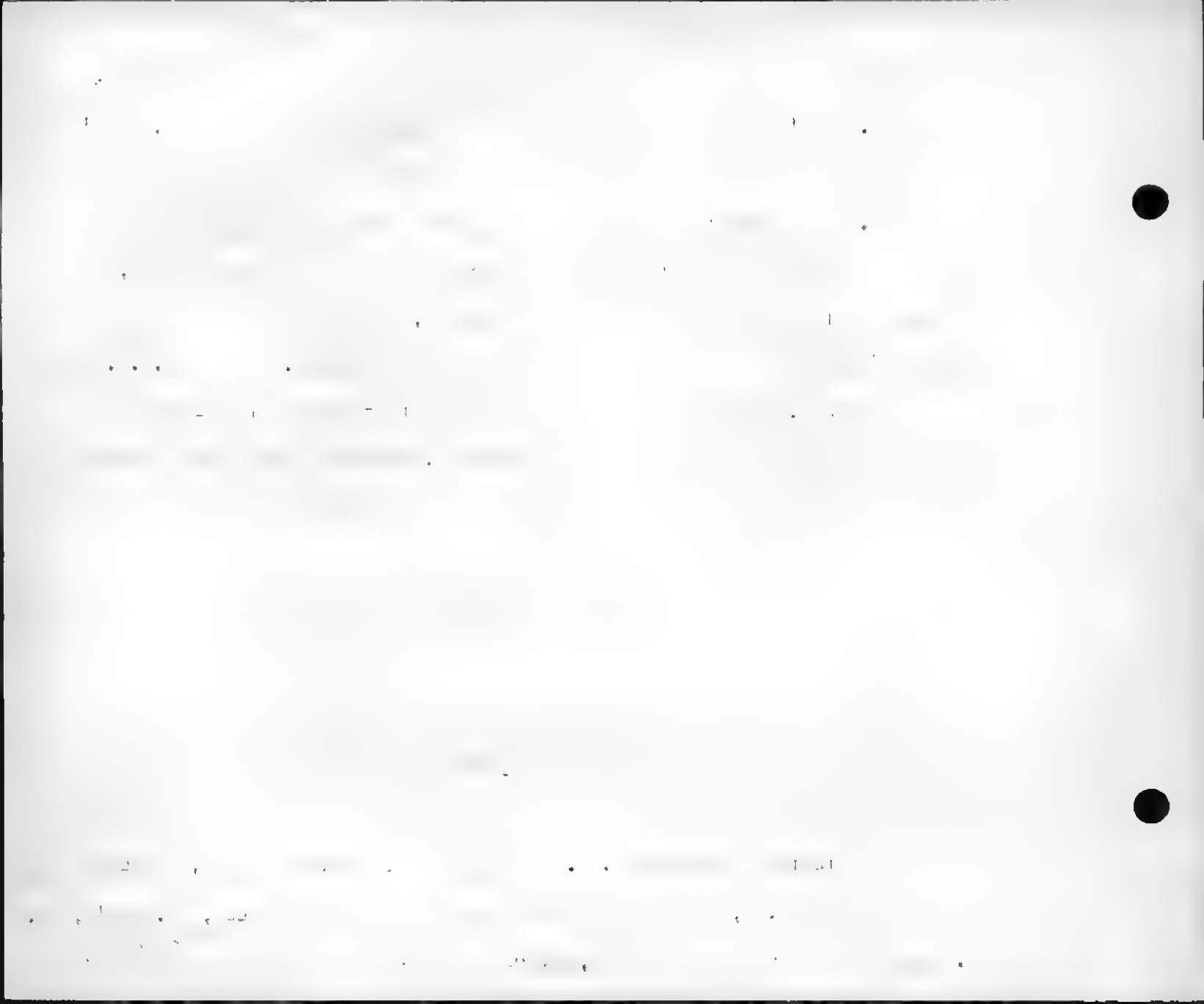
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15978

CERTIFICATE OF DEATH

15970

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c LENGTH OF STAY IN 1b <b>7 WEEKS</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>				d STREET ADDRESS <b>STAR ROUTE Box 123</b>			
3 NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>WINIFRED</b> Last <b>MOORCONES</b>				4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>26</b> Year <b>19 67</b>			
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>JUNE 12, 1905</b>	9 AGE (in years last birthday) <b>62</b> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>PENNA.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOSEPH W. SHORT</b>				14 MOTHER'S MAIDEN NAME <b>WINIFRED McTERIN CLARKE</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT <b>JOSEPH J. MOORCONES</b> Address <b>SAME AS # 2 ABOVE</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the ovary.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>16 mos.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>66</b> to <b>Nov-26, 1967</b> that (I) <del>was</del> last saw the deceased alive on <b>Nov-26, 1967</b> and that death occurred at <b>4:20 P.M.</b> from causes and on the date stated above.							
22a SIGNATURE <b>W.H. Patrick</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <b>11-27-67</b>	
22c PHYSICIAN'S NAME (Type) <b>WILLIAM H. PATRICK M. D.</b>				22d ADDRESS <b>LEXINGTON PARK, MARYLAND</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>Nov. 29, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>HOLY FACE CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>GREAT MILLS, ST. MARY'S MD.</b>	
24 FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>				ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a REC'D BY REGISTRAR <b>DEC 1 1967</b>	
				25b REGISTER'S SIGNATURE <i>[Signature]</i>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

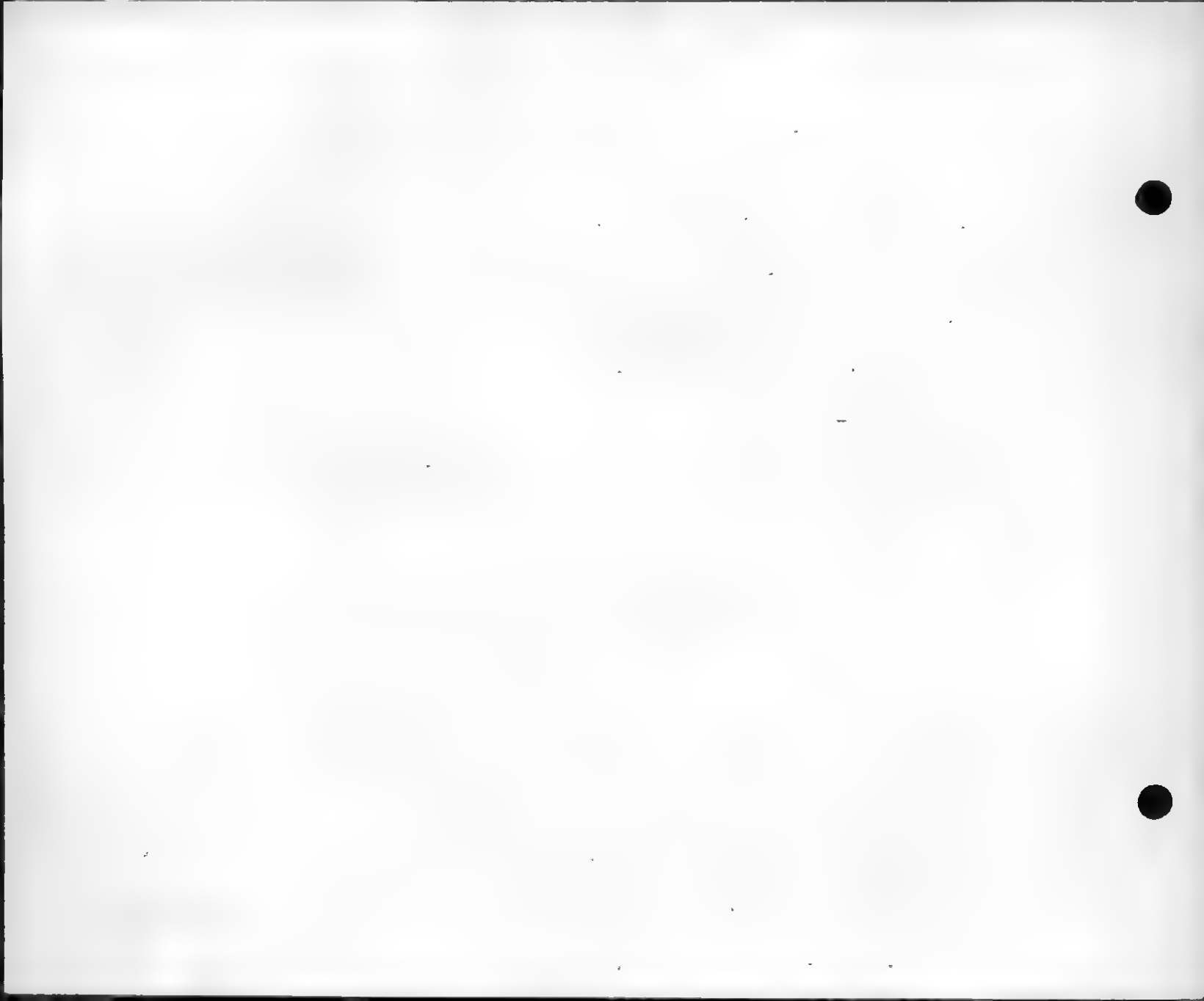
FOR STATE  
HEALTH DEPT.

15970

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15971

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>Patuxent River Naval Air Station</b>		d. STREET ADDRESS <b>425 Essex Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY ANN</b> Middle <b>WAYNEWRIGHT</b> Last <b>MOORE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/14/1935</b>
9. AGE (in years last birthday) <b>32</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min <b>11</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (State or foreign country) <b>FLORIDA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GERALD WAINWRIGHT</b>		14. MOTHER'S MAIDEN NAME <b>MIRIAM UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>BOBBY R. WOLT SAME AS # 2</b>	
17. INFORMANT <b>BOBBY R. WOLT</b>		Address <b>SAME AS # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver</b> <b>5410</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour <b>19</b> m <b>19</b> p m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above and on <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> November 26, 1967 Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT</b>		23b. DATE THEREOF <b>11/27/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>JACKSONVILLE, FLORIDA</b>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			



215 (4)  
1/65

## 4872

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bushwood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Saint Mary's Hospital</b>		d. STREET ADDRESS <b>151</b>	
3. NAME OF DECEASED (Type or print) <b>James Randolph Morgan II</b>		4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-7-67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Leonardtown, St. M. Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Randolph Morgan, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Clara May Joy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b>		Address <b>Bushwood, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerelectasia; by acute meningitis</b> 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/7</b> , 19 <b>67</b> , to <b>11/8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/8/67</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <b>J. Roy Guyther</b>		22c. PHYSICIAN'S NAME (Type) <b>J. Roy Guyther, M.D.</b>	
22d. ADDRESS <b>Mechanicsville, Maryland</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-10-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Morganza Md.</b>	
24. FUNERAL DIRECTOR <b>Mattingley's</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15973

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>VIOLA</b> Last <b>ST. CLAIR</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>FEB. 2, 1887</b>
9 AGE (In years last birthday) <b>80</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>DOMINIC WISE</b>	
14. MOTHER'S MAIDEN NAME <b>LILLIAN YATES</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17 INFORMANT <b>GENEVEIVE ST. CLAIR STONE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive, arteriosclerotic heart disease</b> DUE TO (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>John F. Fenwick</i>		22b. DATE SIGNED <b>11.26.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. FENWICK M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Nov. 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BUSHWOOD, ST. MARY'S MD.</b>
24 FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REG STRAR <b>NOV 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>William J. ...</i>			

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FOR STATE  
HEALTH DEPT.

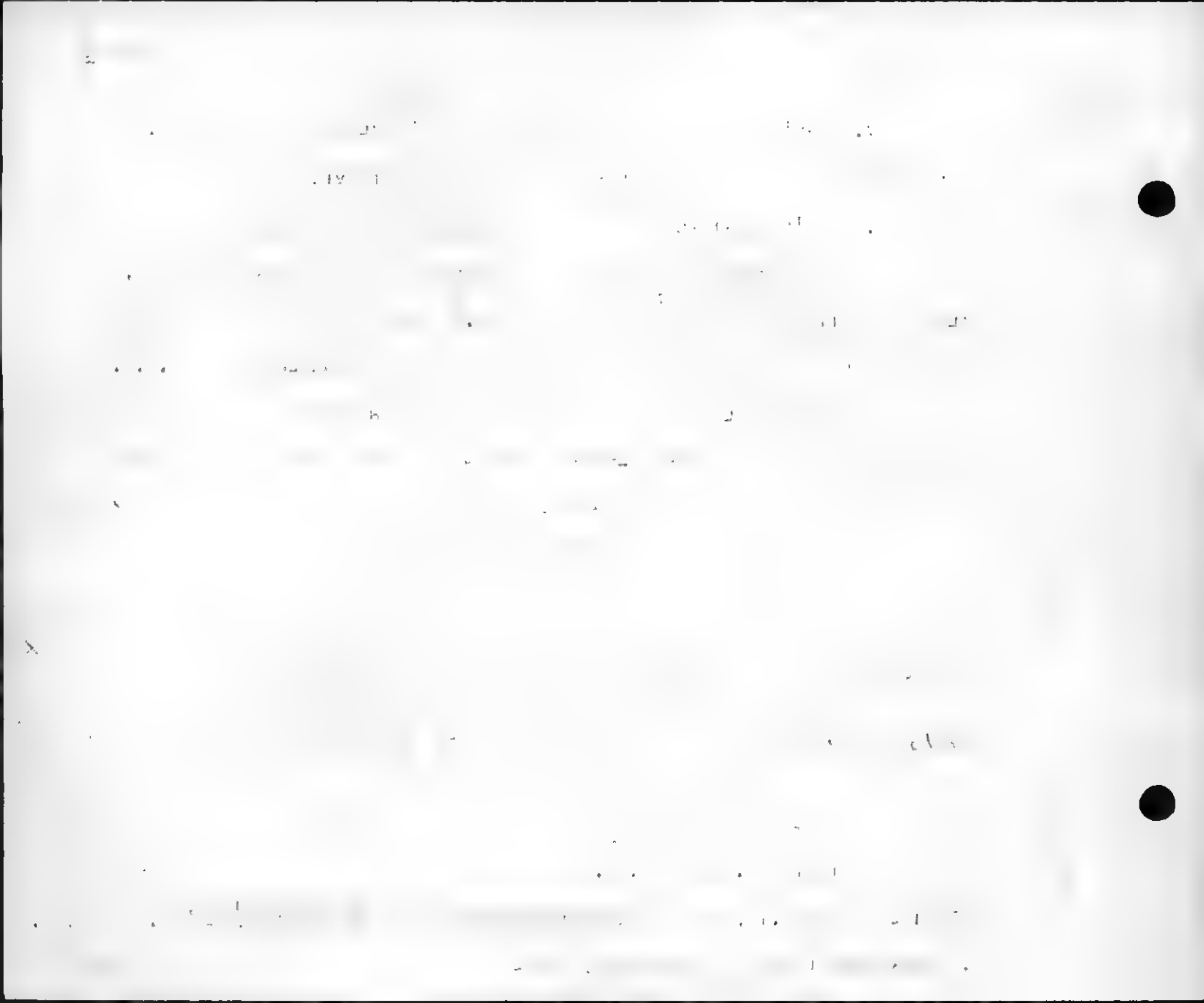
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY in 1b <b>2 HRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE RALPH TAYLOR</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 12, 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1934</b>
9. AGE (In years last birthday) yrs <b>33</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEET METAL</b>		12. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>ANDREW TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>RUTH WILLET</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>4579-44-8712</b>		16. SOCIAL SECURITY NO <b>4579-44-8712</b>	
17. INFORMANT <b>DOROTHY D. TAYLOR</b>		Address <b>SAME AS # 2 ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Brain Laceration</b> 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Basilar Fracture</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 Hr</b> <b>1/2 Hr</b>	
20a. EXTERNAL CAUSE WAS PR. MARYLAND OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver of auto hit by another auto</b>	
20c. TIME OF INJURY Month, Day, Year hour a.m. <b>1:15 - 10-12-1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <b>ROUTE 5</b>		20f. (City or town) (County) (State) <b>Mechanicville St. Mary's Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd</b> M.D.		22. DATE SIGNED <b>11/13/67</b>	
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Nov. 14, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER - GREAT MILLS, MARYLAND</b>	23d. LOCATION (City or Town) (County) (State) <b>St. Mary's, Md.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>William D. Boyd</b>	





15983

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

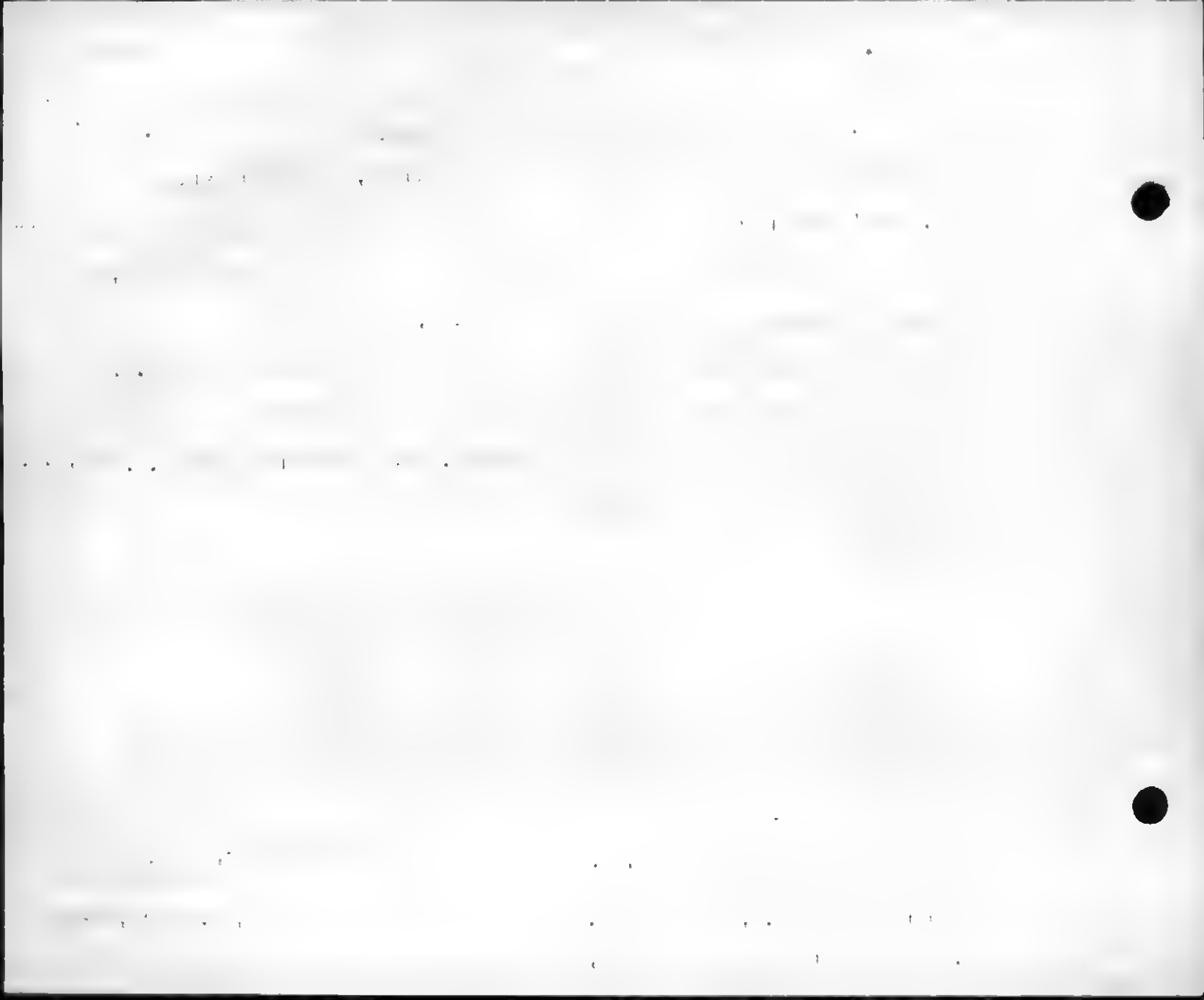
15975

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ORAVILLE, MECHANICSVILLE</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>ROBERTA</b> Middle <b>WHALEN</b> Last 4. DATE OF DEATH <b>NOVEMBER 4, 1967</b>		5 SEX <b>FEMALE</b> 6. COLOR OR RACE <b>COLORED</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>OCT. 7, 1920</b> 9. AGE (In years lost birthday) <b>47</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOSEPH BOND</b>		14. MOTHER'S MAIDEN NAME <b>NAMIE BRISCOE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JAMES A. WHALEN 406 RIGGS ROAD N.E. WASH. D.C.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte Imbalance</b> DUE TO (b) <b>Diabetic Acidosis</b> DUE TO (c) <b>Diabetic Acidosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>18 h</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 4, 1967</b> to <b>Nov 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 4, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>David Mossman</b>		22b. DATE SIGNED <b>11/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID MOSSMAN M. D.</b>		22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 9, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MORGANZA, ST. MARY'S, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
76

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15984

15976

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN,</b>				c. LENGTH OF STAY IN TB <b>9 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>KEATING</b> Last <b>WOODBURN</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>21</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 17, 1885</b>	9. AGE (In years and birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RICHARD K. WOODBURN</b>				14. MOTHER'S MAIDEN NAME <b>SUSIE C. GRAVES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-56-9800</b>		17. INFORMANT <b>J. CLAUDE JOHNSON</b> Address <b>MORGANZA, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>G. I. Hemorrhage</b> DUE TO (c) <b>Adenocarcinoma of Cecum</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1530</b> <b>days</b> <b>hours?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>11/20/67</b> , 19 <b>67</b> , to <b>11/21/67</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>11/20/67</b> , 19 <b>67</b> , and that death occurred at <b>M</b> from causes and on the date stated above.							
22a. SIGNATURE <b>James P. Jarboe</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/21/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe M.D.</b>		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>BURIAL</b>		<b>Nov. 23, 1967</b>		<b>ST. JOSEPH'S</b>		<b>MORGANZA, ST. MARY'S, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>				25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John J. ...</b>	

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

DATE: 10/10/2014

DNA LYSATE : MAGNETICALLY SEPARATED DNA

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 51  
6M 1/67

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15985

15977

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL AVENUE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL AVENUE</b> 18.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LIFE</b>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>TERRY</b> Middle <b>ANDRE</b> Last <b>YOUNG</b>		4. DATE OF DEATH <b>NOVEMBER 22, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 25, 1962</b>
9. AGE (In years last birthday) <b>5</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>JAMES E. YOUNG SR.</b>		14. MOTHER'S MAIDEN NAME <b>GERTRUDE ELIZABETH ARMSTRONG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JAMES E. YOUNG SR.</b>		Address <b>AVENUE, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BURNS EXTREME</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>IMMED</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>HOUSE FIRE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>10/39</b> p.m. <b>11/22</b> 19 <b>67</b>	20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>	20f. (City or town) <b>ABELL</b> (County) <b>ST. MARY'S</b> (State) <b>MD</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd</b> EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>		22. DATE SIGNED <b>11/24/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 25, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		23d. LOCATION (City or Town) (County) (State) <b>BUSHWOOD, ST. MARY'S, MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>NOV 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>W. Clarke Matingley</b>	

1927

ST. LOUIS, MO. MAY 12

DEAR MR. BROWN

YOUR LETTER OF MAY 10, 1927, WAS RECEIVED. I AM SORRY THAT I HAVE NOT BEEN ABLE TO REPLY TO YOU EARLIER. I AM CURRENTLY OUT OF THE COUNTRY AND WILL BE BACK IN TWO WEEKS.

YOURS VERY TRULY

JAMES C. YOUNG JR.

1212 N. 1ST ST. ST. LOUIS, MO.

WILLIAM S. BROWN

1212 N. 1ST ST.

ST. LOUIS

1212 N. 1ST ST.

WILLIAM S. BROWN

1212 N. 1ST ST. ST. LOUIS, MO. MAY 12, 1927

WILLIAM S. BROWN